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T B A C C O

ALERT



EDITORIAL

Since 1970 the World Health Assembly has adopted 13 resolutions calling on Member States to implement comprehensive tobacco control actions, in order to prevent and stop the spread of what is now called the tobacco epidemic.

The African Region, like other regions of the world, is confronted with the problem of scores of tobacco-induced illnesses and deaths.

Public health and medical officials in every country are aware that tobacco consumption contributes to the development of pulmonary and cardiac diseases, including broncho-pulmonary cancer, chronic bronchitis, emphysema and ischaemic heart disease.

Therefore, it is imperative that the tobacco smoking behaviour that is spreading so fast among young people and women in the African Region, should be monitored and controlled in order to prevent the inevitable epidemic of pulmonary cancer and other diseases related to tobacco use.

In developing countries, as a whole, per capita cigarette consumption has risen by over 65%, on average, during the last 20 years and based on current trends, it is predicted that there will be about 7 million deaths a year from tobacco in developing countries within the next two to three decades.

So far, in response to the 13 resolutions, Member States in this Region have initiated, in varying degrees, a number of actions designed to sensitize their populations to the risks associated with tobacco use.

To manage and guide these actions, 26% of Member States have appointed a national focal point on Tobacco or Health, and developed national plans of action on Tobacco or Health. About 10% have recently conducted limited studies on the prevalence of tobacco use in some strata of their populations and all Member States have developed campaigns in collaboration with national tobacco control advocates to sensitize

the public on the ill-effects of tobacco on health. Furthermore, 33% have introduced legislation banning smoking in public places, including schools, health services, airlines, trains and buses, and 25% have banned advertisements on government-owned radio and television,



as well as in newspapers.

All countries participate in the celebration of World No-Tobacco Day held each year on 31 May, by organizing public awareness campaigns.

An increasing number of NGOs are being created in Member States and are developing actions to increase public awareness of the health effects of tobacco use, and to encourage people to undertake tobacco control activities.

All these efforts are laudable. However, the task remaining is still enormous. Much needs to be done in every aspect of tobacco control in order for each country to avert the advancing epidemic. For instance, each country needs to grasp fully the scale and scope of tobacco smoking prevalence and its effects on the health of active and passive smokers amongst its population, and take immediate action to prevent and control them.

In this respect, we believe that each country should continue to deploy efforts in order to:

- Appoint a national TOH focal point where it has not already been done.
- Update or collect nationwide data on

tobacco use and its health effects.

- Create or strengthen national cancer registries in order to ensure the collection of accurate and complete data on the incidence and prevalence of cancer related to tobacco use.
- Intensify public information and education efforts on tobacco and health issues, including smoking cessation programmes.
- Provide protection from involuntary exposure to tobacco smoke in workplaces, public places and on public transport.
- Enact legislation to ban the sale of tobacco and tobacco products in duty free shops, and the importation of these products for resale and export to neighbouring countries.
- Increase taxes to discourage widespread consumption, especially by women and young people.

- Ban advertising of tobacco in local mass media and the sale of cigarettes near schools and other training institutes.

Finally, the international donor community, especially development agencies and the UN system, should increase their financial and technical support to countries in the Region, especially those which are major tobacco producers, to enable them to practice agricultural diversification with the goal of eventually replacing tobacco production by food crops.

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EPIDEMIOLOGY

TOBACCO USE IN AFRICA AND FUTURE HEALTH CONSEQUENCES

Various indirect epidemiological methods, combined with scanty community survey and surveillance data which are available, suggest that tobacco is not yet a major cause of death in sub-Saharan Africa. A recent review of the Global Burden of Disease for the World Bank's 1993 *World Development Report* estimated that there were about 8 million deaths in 1990 in Africa and of these, 4 million were of children aged 0 to 4 years. Improving child survival thus remains a major unfinished agenda and will continue to be the public health priority in the Region. Of the remainder, about 2 million deaths occur each year between 5 and 29 years, and a further 2 million deaths beyond the age of 30. However, on the basis of previous smoking levels, very few of these adult deaths can yet be attributed to tobacco.

This is also quite clear from estimates of the leading causes of death in sub-Saharan Africa in 1990. Acute respiratory infections still kill over a million people each year in Africa, mostly children aged 0 to 4 years. Cardiovascular diseases probably claim around 800 000 to 900 000 deaths a year, 100 000 from heart diseases, 400 000 from stroke and 250 000 or so from conditions such as pericarditis, myocarditis and endocarditis. This is a very different epidemiological pattern to industrialized countries, where inflammatory heart diseases are no longer important causes of death. Each year, malaria kills almost a million people, mostly children, injury and poisonings about 630 000, TB over half a million, perinatal causes another half a million, and measles about half a million. It is estimated that cancer is the cause of about 300 000 deaths a year in sub-Saharan Africa, but only about 20 000 (for both sexes combined) are from lung cancer.

But how is this epidemiological pattern likely to change? Currently, average cigarette consumption per adult is around 500 per year in the Region, although in some countries the consumption is about twice as high. There has

been relatively little absolute change in average consumption in the Region since the 1960s, varying between about 400 and 550 cigarettes per adult per year. This is still comparatively low compared with the world average cigarette consumption of about 1450 per adult per year.

However, unless national and regional tobacco control strategies are effective, there is no reason to expect that cigarette consumption in Africa will not follow the trend observed elsewhere with economic development. The experience of the developed countries in this regard is particularly illustrative. As Figure 1 shows, per adult consumption levels in the industrialized countries around 1920 were similar to what is observed in Africa today. At that time, lung cancer was extremely rare and deaths from smoking were negligible. By 1970, 50 years later, consumption was almost 3000 cigarettes per adult per year and by this time, annual tobacco-attributable mortality in these countries had risen to about one million deaths per year.

Unfortunately, the full health consequences of this dramatic rise in ciga-

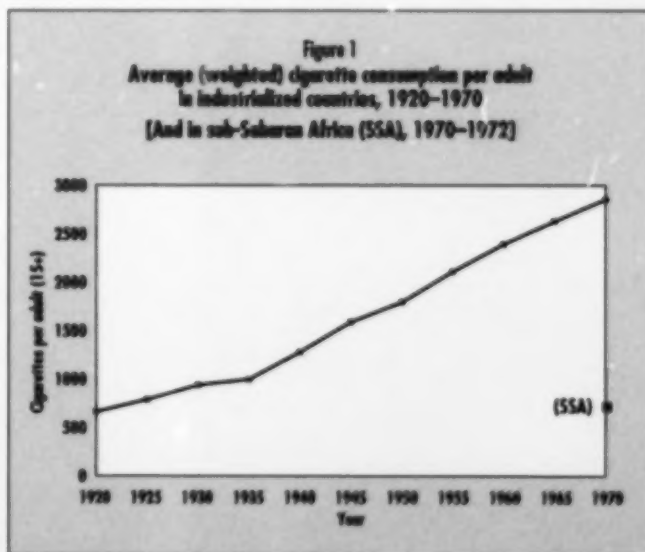
bacco in the industrialized countries. It is expected that this figure will rise even further as the health effects of female smoking become increasingly apparent.

If the health risks of prolonged smoking in Africa are eventually going to be similar to what has been observed in industrialized countries, then it is reasonably straightforward to predict what will eventually happen. There are about 350 million children aged 0 to 19 years alive today in sub-Saharan Africa, 80 million of whom could eventually become regular smokers, based on current prevalence data from the Region.

If this is allowed to happen, and one-third or more of African children become regular smokers and, if, as is happening in industrialized countries, one-third to one-half of regular smokers die from smoking, then tobacco could eventually cause 1 to 2 million deaths per year in sub-Saharan Africa. In other words, 20 to 30 million of all the Region's children that are alive today could eventually be killed by tobacco.

Fortunately, this spectre of a looming epidemic of death caused by tobacco can be largely avoided. African countries of the 1990s have a distinct advantage over industrialized countries of the 1920s—knowledge. In the 1920s, no one knew that rapidly-increasing tobacco use was going to result in a massive epidemic of tobacco-caused death in future decades. But in the 1990s, the fact that tobacco eventually kills one-third to one-half of its users is well-known; this was not known in the 1920s.

Sub-Saharan Africa, the last major region of the world where tobacco use is not yet widespread, has the opportunity to benefit from this new knowledge, and prevent a widespread tobacco epidemic from ever occurring. By taking inexpensive but comprehensive action now to prevent tobacco use from ever becoming widespread, the future impact of tobacco-related death and illness can be dramatically reduced.



rette consumption were, even at that time, yet to be felt. Although average adult consumption in the industrialized countries did not rise much above the early 1970s level, deaths due to smoking continued to increase and today about 2 million deaths each year are due to to-

WHO/TOH PROGRAMME

TOBACCO OR HEALTH IN THE AFRICAN REGION

1. Introduction

This article reviews the tobacco or health situation in the African Region and proposes a framework for regional strategies to prevent and control the use of tobacco and to protect the health of nonsmokers.

Tobacco smoking is dangerous to smokers and nonsmokers alike, particularly to children through the damaging effects of enforced passive smoking. In the long term, tobacco consumption is both a major health hazard and an economic burden to national economies, in view of the associated health and social costs. However, tobacco production plays a significant role in the economies of some African countries, in particular Zimbabwe, Malawi, Kenya and, to some extent, Uganda, Tanzania and Madagascar. Campaigns aimed at reducing tobacco production and consumption must therefore take into account an already weak economic base in these countries; comprehensive tobacco control programmes will need to include alternative economic activities to replace tobacco production.

Since 1970, the World Health Assembly has adopted 13 resolutions, calling on Member States to implement comprehensive tobacco control actions.

2. The situation

There is relatively little information on this topic. There is neither reliable information on the prevalence of smoking nor on mortality and morbidity related to tobacco consumption in the Region, making it difficult to present a realistic picture of the tobacco or health situation in the Region.

In April 1993, a questionnaire was prepared and sent to the 44 Member States of the African Region to collect updated additional information on the tobacco or health situation in each country. Twenty-eight of the 44 Member States or 64% of all countries of the WHO African Region returned the completed questionnaires.

Agriculture

Tobacco is grown practically in all countries of the Region except Comoros, Gambia and Gabon. The scale of production goes from small plots to large-scale plantations such as in Malawi, Zimbabwe, Côte d'Ivoire, Tanzania, Madagascar and South Africa. Compared to English-speaking countries of the WHO African Region, French-speaking countries are small-scale producers. It is important to point out, however, that the African Region includes among its Member States the world's second largest exporter of quality tobacco: Zimbabwe. However, compared with that in other regions of



the world, African tobacco production remains low.

Manufacturing and trade

It has been estimated that the cigarette consumption market will continue to grow mainly because of the increased volume consumption in the developing countries, including those of the African Region. For now, the general world economic crisis has led to stagnation or a noticeable decrease in the volume of cigarette consumption in countries like Côte d'Ivoire, Togo and Senegal.

Advertising and marketing

In the African Region, advertising and marketing of tobacco and tobacco products have gained momentum in recent years. All types of mass media and vending techniques are used to convey what are sometimes misleading messages to young people with dreams of western lifestyles of affluence and luxury. Free cigarettes are often distributed in bars, hotels and dancing halls, a practice which has alarmed some governments, citizens' associations and numerous non-governmental organizations. In the past few years, a number of countries in the Region have enacted laws and regulations to restrict certain aspects of cigarette handling and consumption in public.

However, in the African Region, legislation to regulate tobacco production, manufacturing, marketing, sale and consumption, is still lagging behind that of countries in other regions.

3. Framework for developing a regional strategy

Given the complexity of the economic, political and social issues involved, WHO is the only international body that could provide legitimate leadership in directing and coordinating national efforts, in partnership with nongovernmental organizations. While the progress made by WHO so far is good, much more could and should be done to strengthen its advocacy role, expand its clearinghouse function, and intensify the exchange of information.

If the WHO goal of *Health for All by the year 2000* is to be achieved, there is an urgent need for national tobacco con-

trol programmes aimed at freeing communities of tobacco use by this date, in the context of primary health care. The ultimate goal is to minimize premature death and disability that cause both suffering to the individual and aggravate social costs.

Goals and objectives

The major goals are primary prevention, protection of nonsmokers' rights and substituting food crops and other socially useful crops for tobacco.

The specific programme objectives are to:

- promote the development of national programmes to prevent and reduce tobacco use;
- promote the concept of tobacco-free societies and to establish non-use of tobacco as normal social behaviour;
- disseminate information on tobacco or health issues and strategies to control tobacco consumption.

Strategies

Immediate action should be taken in each country employing whatever political, social and educational steps that are feasible; the longer governments wait the more deeply rooted the smoking problem becomes. It should be recognized, however, that large-scale change takes time and careful planning, and that a long-range plan is needed for systematic, comprehensive and continuous action.

• Data collection

Smoking control action should be based on the best possible knowledge of smoking-related factors in the population. The first step should be to collect data for the proper assessment of priorities for smoking control programmes. Wide publicity of the data collected and their analysis would contribute to an appreciation of smoking as an important public health problem. Such baseline data would also be required for the evaluation of programme impact through pre-intervention and post-intervention comparisons and, if standardized in the different countries, would make international comparisons possible.

• Public information and public education programmes

Public information and public education programmes comprise a vast range of activities and reflect the desire of governments, health agencies, and others to improve knowledge and change attitudes and behaviour in the community at large. As such, they should be integrated and run by either government or nongovernmental bodies.

A public information programme is generally seen as a mass communication approach aimed primarily at cre-

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AFRICA: THE COMPLEXITY OF THE TOBACCO ISSUE

For some African countries, tobacco is an important source of income, and during the past few years the World Health Organization, in its tobacco control campaign, has received repeated messages from a number of developing countries that are dependent on tobacco production for their socio-economic development.

Recognizing the complexity of the issue and reaffirming the need for multisectoral strategies, including the involvement of other members of the United Nations system, in dealing with the serious health and socio-economic aspects connected with tobacco production and consumption, the Director-General of WHO, at the request of the World Health Assembly, presented the issue to the Economic and Social Council of the United Nations (ECOSOC), stressing

the need for a multisectoral and multilateral approach to the solution of such social and economic matters. Such a conclusion was endorsed by ECOSOC, which adopted Resolution E/1993/79, requesting the Secretary-General of the United Nations to establish, under the auspices of WHO, a focal point within existing institutions within the United Nations system, on the subject of multisectoral collaboration on the economic and social aspects of tobacco production and consumption, taking into particular account the serious health consequences of tobacco use.

In response, the Secretary-General requested the United Nations Conference on Trade and Development (UNCTAD), to designate a focal point within UNCTAD to undertake the coordination responsibilities emanating

from this resolution.

The focal point for multisectoral collaboration on tobacco or health has since been established within UNCTAD and the coordinating functions have been designated to Mr Raul Uranga, the Senior Economic Affairs Officer, who will work under the direct guidance of Mr Carlos Fortin, Deputy to the Secretary-General of UNCTAD and Director of the Commodities Division.

It is expected that individual plans of work, setting out goals and targets for each UN agency's contribution to multisectoral collaboration on tobacco or health, will lead to a reduction in the burden of disease and death caused by the tobacco pandemic, while giving due consideration to any economic adjustments that may arise from a reduction in the demand for tobacco products.

(continued from page 3)

ating and intensifying awareness of the nature and magnitude of the smoking problem. Mass media are useful in reaching, often simultaneously, wide audiences that include groups such as politicians, professionals, housewives, workers, young people, and religious and traditional leaders. Each of these groups has powerful influence over its constituents and followers.

Public education programmes are usually concerned with reaching specific target groups. A relatively large number of people in different institutions need to be involved in the educational work at community level. Programmes should be multidisciplinary in their origin and should integrate the activities of professionals from various disciplines with workers in voluntary organizations. In principle, the following may be involved in educational activities: all medical professionals, other health personnel, and traditional healers particularly at the primary health care level; school teachers; community and religious leaders and institutions; youth associations; women's associations; leaders in the workplace; and active people in different clubs and voluntary organizations.

Efforts should be made to ensure that the training of doctors, nurses and other health personnel includes information on the adverse health effects of smoking.

- **Restrictive measures and legislation**
A broadly defined education programme aimed at reducing smoking must be complemented by legislation to combat tobacco use and tobacco-related diseases. Any programme of legislation must be realistic in its choice of areas and legislation should be introduced only if it can be implemented.

There are two main categories of smoking control measures. Those leading to changes in habit among persons engaged in the manufacture, promotion or sale of cigarettes (e.g. promotional bans, reduction in tar, nicotine and carbon monoxide yields); smokers (e.g. restrictions on smoking in public places, high taxes on cigarette sales, setting of minimum age limit for purchase) and restrictive measures and legislation which may be effective in: health warnings; mandatory health education on smoking; smoking in public places and workplaces; advertising and sales promotion; tobacco cultivation in countries that do not as yet cultivate tobacco on a commercial scale, such a development should be prevented, by legislative means if possible; product modification and description; price policy; distribution of cigarettes.

The main goals of tobacco legislation are to: reduce smoking or ensure that it does not increase; complement educational activities, which are likely to become more effective when backed by law; demonstrate governmental concern; influence public attitudes to smoking by regulating promotional activities; reduce the hazards to health of those who continue to smoke and limit the exposure of nonsmokers to tobacco smoke.

Specific activities

Based on recommended strategies, specific activities which will be necessary for the African Region are to: appoint a national focal point for tobacco or health; create a national commission on tobacco or health; develop an effective national tobacco or health programme with decentralized structures in accordance with the African framework for health development; develop a public information and education programme on tobacco or

health; introduce in primary and secondary schools teaching modules on tobacco or health; adopt legislation banning smoking in public offices, public transport, and in the workplace; encourage private industries and commerce to provide smoke-free work environments for their staff and clients; introduce high taxes on tobacco and tobacco products; ban the advertisement of tobacco and tobacco products on national mass media; prohibit the sale of cigarettes near and around schools and health facilities; develop a reliable epidemiological monitoring system to routinely assess the extent of tobacco use as well as levels and trends of diseases caused or linked to tobacco use; develop alternatives to tobacco growing by promoting other profit-making crops; create clinics and counselling programmes for smoking cessation for those who want to stop or who have just stopped smoking; create a national tobacco or health documentation bank; promote and support NGOs that combat tobacco smoking in their localities; create a network of tobacco or health information centres for advocacy throughout the country.

4. Conclusion

In most African countries, the major health problems are still malnutrition and infectious diseases. However, if the smoking epidemic is allowed to spread unchecked, these countries will shortly find that the cost of treating these health problems will be aggravated by the cost of dealing with diseases caused by smoking. Furthermore, the apparent short-term economic advantages of growing and manufacturing tobacco products will ultimately be outweighed by a massive rise in mortality and morbidity due to smoking, and the additional economic burden of treating smoking-related diseases.

TOBACCO AND DISEASE IN AFRICA*

Although reliable comprehensive epidemiological data are lacking in most African countries, there are nonetheless many other sources of information, such as autopsy records or cancer registries, which indicate that the health consequences of smoking are becoming more apparent in African countries.

Lung cancer was apparently very rare in several native African countries before manufactured cigarettes became

freely available. Four detailed cancer registry studies in men were carried out over 30 years ago in Nigeria, Uganda, Kenya and Mozambique, and each showed that less than 2% of cancers were of the lung (Table 1). By comparison a third of all male cancers in England and Wales are of the lung.

Since 1980, reports from several African countries have shown a wide variation in the proportion of reported

malignancies due to lung cancer. These vary from less than 1% in Tanzania to about 25% in some countries (Table 2). Those with the highest rates include countries with the highest per capita cigarette consumption. Time trends of cancer rates for both smokers and nonsmokers in different African countries are badly needed to see whether rates are increasing as a result of growing cigarette consumption in recent years.

The risk of tobacco-induced cancer in Africa is aggravated by the fact that tobacco may interact with other risk factors. These include bladder cancer associated with bilharzia, oesophageal cancer with alcohol consumption, as well as oral cancers from tobacco chewing.

Coronary Heart Disease (CHD) was rarely found in native Africans until recent years. In six autopsy studies between 1937 and 1973, CHD was found in less than 1% of cases (Table 3). Although CHD occurs frequently among Asians in Kenya and in South Africa, it is now affecting the indigenous African population, especially those of the business and professional classes.

Reports from several francophone native African countries show that in recent years CHD has become a well recognized condition, although it is still less common than rheumatic and hypertensive heart disease. In several of these studies "tabagisme" (usually defined as the consumption of more than 10 cigarettes a day) was considered an important risk factor, and many subjects were found to be of higher social class.

Although many African men smoke and hypertension is common, coronary disease is not at present a major public health problem; this is likely to be due to the protective effect of physical activity combined with the generally low serum cholesterol levels due to their low fat and high fibre vegetable diets. If the smoking and eating habits of industrialized countries are widely adopted then CHD rates are almost certain to rise.

Chronic bronchitis could also become a major problem in African smokers, especially where childhood acute chest infections are common and dusty or smoky conditions prevail in the home. Urban air pollution and occupational exposure in mining and heavy industries may aggravate the situation.

The major impact of tobacco consumption has not yet reached many African countries, despite the efforts of the multinational tobacco companies. There may still be time to limit the epidemic, but there is certainly no time to lose!

TABLE 1 Total number of all cancers, and lung cancers, in men in four African countries, based on studies between 1944 and 1963

Region/Country	All cancers	Lung cancer	Histological proof (%)
Ibadan, Nigeria (1960-63)	318	5 (1.6%)	89%
Kampala, Uganda (1957-63)	421	8 (1.9%)	71%
Nairobi, Kenya (1957-61)	1502	18 (1.2%)	100%
Maputo, Mozambique (1944-57)	842	3 (0.36%)	100%

(Figures in parentheses show lung cancer as a % of all cancers.)

TABLE 2 Lung cancer as percentage of all cancers (males only) in 12 African countries, 1980-1990

	%
Seychelles	26.8*
South Africa	22.5*
Mauritius	22.3*
Tunisia	18.0+
Algeria	14.4+
Egypt	9.6+
Mali	4.4+
Zambia	3.6+
Zimbabwe	3.4+
Gambia	2.7+
Senegal	1.2+
Tanzania	0.37+

*: based on deaths
+: based on cases

Source: Cancer registries, vital registration, epidemiological studies.

TABLE 3 Six postmortem studies of CHD in five African countries, between 1937 and 1973

Author	Country	Autopsies	CHD
Williams et al, 1954	Uganda	1 773	0
Devier, 1948	Uganda	2 994	8
Becker, 1946	South Africa	3 000	6
Vint, 1937	Kenya	1 000	2
Eddington, 1954	Ghana	3 645	30
Falomo et al, 1973	Nigeria	6 817	8
	Total	19 229	54 (0.28%)

* A list of reference sources is available from the Tobacco or Health programme, World Health Organization, 1211 Geneva 27, Switzerland.

ALL AFRICA CONFERENCE ON TOBACCO CONTROL

Co-sponsored by WHO, the largest and most important pan-African conference on tobacco control yet took place in Harare, from 14 to 17 November 1993. One hundred and ten delegates from 16 African nations and seven other countries attended, together with representatives from the following organizations: World Health Organization (WHO); International Agency for Research on Cancer (IARC); Centers for Disease Control (CDC), Atlanta; International Development Research Centre (IDRC), Canada; International Union against Cancer (UICC); the World Bank; the Imperial Cancer Research Fund (ICRF), United Kingdom; and representatives of the International Tobacco Growers' Association (ITGA).

Dr Timothy Stamps, Minister of Health, Zimbabwe, in his opening remarks called for Zimbabwe to reduce its over-dependence on tobacco, and simultaneously highlighted the Ministry of Health's commitment to reducing and preventing the health effects of tobacco through public education programmes and restrictions on the promotion of tobacco.



Dr Ukosagana Zuma, National Executive Committee, African National Congress (ANC), South Africa, confirmed Mr Nelson Mandela's strong commitment to tobacco control as being integral to human development, and emphasized the need in South Africa to ensure that as political transformation unfolds, it results in improvements in the health of the population. More specifically, the ANC is committed to implementing a comprehensive tobacco control programme that includes: legislation to restrict advertising; the specific targeting of the black population and children; and the encouraging of grassroots organizations to mobilize against tobacco use.

Former President of the United States of America, Mr Jimmy Carter, provided strong support to the Conference in a letter of solidarity which clearly reiterated his commitment to tobacco

control. The Carter Center has been very active in tobacco control efforts in Africa, and President Carter has personally addressed heads of state and ministries of health in a bid to encourage them to take the necessary steps to prevent a tobacco pandemic in the Region.

Dr G.L. Monekosso, WHO Regional Director for Africa, in a message read at the opening of the Conference, expressed his satisfaction that not one African country had chosen the tobacco camp and that all countries had elected to join the health camp, as confirmed by the fact that each year new tobacco control programmes are created in Member States of the Region, and that many more countries in the Region have appointed focal points for Tobacco or Health. He remarked that since 1986, there has been a gradual awareness of the incidence of tobacco-induced diseases among old and young, male and female, and urban and rural smokers in the Region. He also recalled that a number of countries in the Region whose economies are based on tobacco and tobacco products require international assistance to enable them to turn to alternative sources of foreign currency.

WHO/TOH PROGRAMME

THE WHO TOBACCO OR HEALTH PROGRAMME AT THE ALL AFRICA CONFERENCE ON TOBACCO CONTROL

The health status of the peoples in developing countries is a major concern of the World Health Organization, as these countries are unable to cope with the social and economic costs of further avoidable ill-health associated with tobacco use. Unfortunately, it is in developing countries that we find the fastest growth rate of tobacco consumption today.

Indeed, tobacco is an international problem and the timing of the All Africa Conference could not be better as it offers a unique opportunity to take vigorous action towards the prevention of a tobacco pandemic.

For many African countries, the past twenty years have been disastrous. The Region has been ravaged by natural and man-made disasters, and most of its countries share many similar unfavourable characteristics: low levels of socio-economic development associated with high infant and general mortality, and low life expectancy at birth. Although infectious diseases will continue for some time to be the main cause of death in Africa's developing countries, increasing

rates of tobacco consumption will eventually mean a dramatic increase in tobacco-induced diseases.

In countries with poor health infrastructures which are overburdened by infections and malnutrition, the challenge is to prevent the problem from developing into a public health tragedy.

Fortunately, most African countries still have low rates of tobacco consumption; they could serve as potential examples of true primary prevention.

Thus, the African continent, in all its rich diversity, offers, in many countries where tobacco use is low, the best hopes for avoiding the looming epidemic and the addiction that threatens to spoil much of the progress made in health development in the Region. Therefore, the ultimate response must be the eradication of virtually all tobacco use. This would undoubtedly be the most effective means of protecting present and future health in the Region.

NEWS BRIEF

YOUNG PEOPLE AGAINST TOBACCO: INTERNATIONAL FESTIVAL IN GREECE

The First International Festival of Non-Smoking Youth will take place in Athens, Greece, from 11 to 14 July 1994. Organized by Hellenic Action Against Cancer, with the sponsorship of WHO and several institutions committed to the control of this disease, the Festival is open to young people between 18 and 22 years of age from all over the world. They are invited to take part in this large

gathering and to express their tobacco control message in one of the following categories: essays, drawings and photographs, strip cartoons, videos, music, dance, theatre, sports or any other way. This new-style festival illustrates the growing importance that the promoters of the tobacco control movement attach to prevention among young people.

LEGISLATION

TOBACCO CONTROL LEGISLATION IN WHO'S AFRICAN REGION¹

We survey in this article legislative measures taken by countries in WHO's African Region, a region that covers most of the African Continent other than Morocco, the Libyan Arab Jamahiriya, Egypt, Sudan, Somalia and Djibouti. According to recent WHO estimates, per capita adult consumption in the African Region increased by 2.1% per year between 1970-72 and 1990-92, more than twice the global annual increase of 0.9%².

According to available information, the following African countries currently have tobacco control legislation: Algeria, Benin, Burkina Faso, Côte d'Ivoire, Gambia, Kenya, Mauritius, Niger, Nigeria, Senegal, Zaire and Zambia.

Restrictions on advertising

There is a total ban on tobacco advertising in three countries (Algeria, Gambia and Niger), while in Burkina Faso a 1988 Order prohibits only advertising on billboards and screens. Advertising must be accompanied by health warnings in Nigeria and Zambia. In Zaire, tobacco advertising must not promote smoking nor be intended for young audiences and minors may not take part in any form of advertising. In Senegal, 1985 amendments to a 1981 Law lifted a total ban on advertising; only television advertising is now prohibited, all other media being acceptable under certain conditions (mostly aimed at protecting minors). The free distribution of tobacco products as a

means of promotion is specifically prohibited in Senegal and Zambia.

Restrictions on smoking in public places

Three countries (Senegal, Algeria and Côte d'Ivoire) have legislation restricting smoking in public places in general, whereas in Mauritius, Nigeria, Zambia and Burkina Faso, smoking is prohibited in various public places such as health establishments, public entertainment areas, educational institutions, kindergartens, lifts, and public transportation. An Ordinance promulgated in Niger in 1993 specifies that smoking is prohibited in closed public places and on public transportation. In Benin, smoking is prohibited in health establishments in both the public and private sectors.

Health warnings on cigarettes

Such warnings are mandatory in at least seven countries (Algeria, Burkina Faso, Kenya, Mauritius, Senegal, Zambia and Nigeria). Nigeria provides for two alternative rotating health warnings. The Senegalese text provides that the warning must state "*Abus dangereux pour votre santé*" ("Abuse endangers your health"); "The Federal Ministry of Health warns that tobacco smoking is dangerous to health"; and "Smokers are liable to die young".

Sales of tobacco products to minors

According to available information, only Zambia and Mauritius appear to prohibit sales of tobacco products to minors. These

two countries also specifically restrict smoking in schools.

Levels of harmful constituents in tobacco products

In three countries (Burkina Faso, Nigeria and Senegal), the legislation provides that cigarette packages must show the levels of tar and nicotine. In Senegal, the legislation specified the methods to be used for determining the levels of these constituents.

Smokeless tobacco

In Gambia, the Tobacco Products (Control of Advertisements) Act, 1986, includes in its definition of "tobacco product" any form of tobacco intended for chewing; as a result, advertisements for chewing tobacco are banned. It is unclear whether any of the other items of legislation referred to above apply to smokeless tobacco.

¹ The information contained in this article is based largely on materials published in WHO's *International digest of health legislation* and on the following source: Roemer, R. *Legislative action to combat the world tobacco epidemic*, 2nd Edition. WHO, Geneva, 1993. For operational reasons, it was not possible to consult the WHO Regional Office for Africa, in Brazzaville, in its preparation.

² These estimates of cigarette consumption are based on data provided by the United States Department of Agriculture and the United Nations Statistical Office.

NEWS BRIEFS

TOBACCO-FREE LILLEHAMMER

Unanimously acclaimed as the most "ecological" Winter Olympic Games ever, the Lillehammer Games were, of course, tobacco-free, as has been the tradition since Seoul in 1988. Under an agreement signed by the WHO Regional Office for Europe with the Organizing Committee and the Norwegian Ministry of Health and Social Affairs, smoking was banned at all indoor events, and the sale of cigarettes was banned

at all Olympic sites. Moreover, all the paid and voluntary staff refrained from smoking while working, and the public was asked to refrain also, even in the open air.

A nationwide campaign was launched by the Norwegian Council on Tobacco and Health, by the Norwegian Union Against Cancer, by the Heart Association and by the Norway Medical Association. Anti-smoking posters intended by

their creators to "arouse curiosity", were printed in several languages (English, French, Greek, Japanese, Lapp and Russian) and displayed in public places throughout the country during the XVIIth Winter Olympic Games. Through this series of ambitious and spectacular actions, Norway, where tobacco advertising is prohibited, proved once again that it is at the forefront of the fight against smoking.

UNITED STATES OF AMERICA: 30 YEARS OF FEDERAL COMMITMENT AGAINST SMOKING

"Tobacco can endanger your health". If this kind of warning on cigarette packets nowadays seems natural and commonplace, it certainly was not 30 years ago when it appeared for the first time following a report by the Surgeon-General. That famous report published in 1964 was followed by many others, and warnings to consumers now appear on labels in most countries of the world. On this anniversary, the Coalition on Tobacco or Health, which is made

up of the American Heart Association, the American Lung Association and the American Cancer Association, stresses the lack of progress made, in its opinion, in the fight against smoking, and the need to strengthen activities in this field. In a report just published, the Coalition points out that 30 years after the first official warning against the dangers of smoking, the epidemic is still rife in the United States, where it kills some 420 000 people each year. The report rec-

ommends a number of conspicuous measures which need to be taken by the Federal authorities without delay: the President of the United States should declare a ban on smoking in all official buildings, restrictions on smoking should be introduced on the premises of Congress, and those responsible for foreign trade should ensure that the commercial policies of the United States do not prejudice the laws passed by other countries to protect the health of their people.

IARC

TOBACCO-RELATED CANCER IN AFRICA

During the All Africa Conference on Tobacco Control, held in Harare, Zimbabwe, from 14-17 November 1993, a review was made of how much we know, how much we have yet to discover and what we can do to obtain better knowledge of the tobacco-related burden in Africa.

In order to evaluate this burden correctly, it is necessary to have reliable data on:

1. Cancer occurrence (mortality or preferably incidence);
2. Prevalence of tobacco use in its various forms and not only manufactured cigarettes;
3. The precise relationship between tobacco use and disease for each specific country.

Information on these factors is not widely available in the Region although there are some populations for which data are gathered through the International Agency for Research on Cancer (IARC). Such involvement is still limited but results are promising.

Recent incidence data from Africa

In the most recently published edition of *Cancer incidence in five continents*, three African cancer registries were included. This clearly demonstrates the feasibility, in spite of many difficulties, of collecting good quality and reliable information on the occurrence of cancer in Africa. All the figures provided are population-based and cover between 750 000 to 1 000 000 inhabitants. One is a national registry (Gambia) and the other two are local registries (Setif Wilaya in Algeria and Bamako in Mali).

Overall cancer rates in men, after adjustment to the world population, are

highest in Bamako (122 new cases per 100 000 person-years), intermediate in Setif Wilaya (72) and lowest in Gambia (59). Ranking is similar among women with figures of 103, 65 and 40 respectively. Women therefore experience lower (by 10-20%) overall cancer rates than men, a finding consistent with patterns observed elsewhere.

More importantly, a more than tenfold difference exists for the occurrence of lung cancer. The highest male incidence is found in Setif Wilaya at 12 per 100 000 versus 3 in Bamako and 1 in Gambia. Among women, lung cancer rates are still very low, typically less than 2 per 100 000. It is worth noting that they are not strictly parallel to the rates in men, with women from Algeria having lower lung cancer rates than women in Bamako, whereas the highest rate among men is in Algeria. Oral cavity cancer is very rare in these registries.

Results of case-control studies of tobacco use and specific cancer sites in Bulawayo

Several case-control studies have been conducted based on data from the Bulawayo Cancer Registry, with cases being a specific cancer site and controls being all other cancers, with the exception of those suspected as being linked to tobacco use. Odds ratios (OR) of cancer linked to tobacco use were computed as estimates of relative risk and the main results are indicated in Table 1 (95% confidence intervals for the odds ratios are given in parentheses). The greatest increase in risk is seen for oesophagus and lung cancer, both with manufactured and home-made cigarettes.

NEWS BRIEF

EVEN BONES ARE NOT SAFE FROM SMOKE

According to a study carried out by a team from Melbourne University, the bones of a woman who had smoked one packet of cigarettes a day throughout adulthood had lost 5-10% of their density by the time she reached the menopause, thus increasing the well-known risks of fracture associated with osteoporosis. This study clearly shows that smoking weakens the bones by modifying the texture of the bone tissue. Dr John Hopper and Dr Ego Seeman, who published their findings in a recent issue of the *New England Journal of Medicine*, studied 41 pairs of twins, and this permitted very convincing comparisons. Smoking also increases the risk of fracture in men, of course, but because of the phenomenon of menopause, women are a much more vulnerable group.

WORLD NO-TOBACCO DAY

The theme for World No-Tobacco Day, 31 May 1994, is:

"The media and tobacco: getting the health message across"

WORLD HEALTH ORGANIZATION

WHO NEWS

The media and tobacco

"Getting the health message across"

• Ban on advertising and promotion
 • Banning smoking
 • High tobacco taxes
 • No tobacco advertising
 • Strong health warnings
 • Health care promotion
 • Protect children and women

TABLE 1

Adjusted odds ratios for total tobacco use in men in Bulawayo, Zimbabwe, 1963-1977

Cancer sites	Nonsmoker (Reference group)	Ex-smokers	Smokers of:	
			< 15/day	> 15/day
Oesophagus	1.0	3.5 (1.9, 6.4)	3.7 (2.8, 4.8)	5.6 (3.7, 8.5)
Lung	1.0	3.4 (1.9, 5.8)	3.9 (3.0, 5.0)	5.2 (3.5, 7.8)
Liver	1.0	1.3 (0.7, 2.4)	1.3 (1.0, 1.6)	1.4 (0.9, 2.1)
Bladder	1.0	0.3 (0.1, 1.2)	1.0 (0.7, 1.3)	1.3 (0.8, 2.2)

Conclusion

Tobacco use is a truly avoidable cause of death and disease, causing about three million deaths throughout the world every year. Unfortunately, there are as yet relatively few studies to reliably document the risks of tobacco use in Africa. Simple studies which can be implemented rap-

idly are urgently required in order to better evaluate these risks. Data from such local studies will be of scientific interest, but more importantly will also provide locally-specific information to support the implementation of policies to prevent the further spread of the tobacco epidemic.



This newsletter is issued by the WHO programme on Tobacco or Health (TOH), World Health Organization, 1211 Geneva 27, Switzerland. The text may be freely reproduced and illustrations may be used, giving credit to WHO. Cuttings are requested. Contributions and suggestions to be addressed to Dr J.R. Menchaca, Programme Manager, Tobacco or Health.

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